Mail completed form to:
Department of the Corporation Counsel
530 South King Street, Room 110
Honolulu, Hawaii 96813

CLAIM FORM

FOR OFFICE USE ONLY
Claim No.

INSTRUCTIONS

1. This claim will not be processed unless filled in completely. **Print in ink or use typewriter.**
2. Original and two copies of claim and attachments must be submitted.

CLAIMANT NAME		Occupation
Residence Address	Place of Employment	Phone RES: _____ BUS:
Location of Occurrence/Address		Occurred DATE: _____ TIME:
Extent of Injury/Damage		
How Injury/Damage Occurred		
Witness(s) to Accident/Injury: **NAMES**	**ADDRESS**	**PHONE NO.**
Amount of Claim	If medical, attach doctor's reports and bills. Other damages, itemize or attach bills or estimates.	
The MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT of 2007 (MMSEA) requires the reporting of certain information from all personal injury claimants to determine if the claimant is or will be a Medicare beneficiary. Payments may not be made on this claim if this information is not provided. All information will be kept confidential and only used for reporting purposes. Please see Attachment "A".		

Dated: _____

NOTICE:
Filing a false claim is a violation of Hawaii Revised Statues §46-171, *et seq.*, and could result in a civil penalty of not less than $5,000 and not more than $10,000, plus treble damages.

BY SIGNING THIS FORM, I HEREBY CERTIFY THAT THE INFORMATION AND CLAIM SUBMITTED ARE TRUE AND CORRECT.

_____
SIGNATURE OF PERSON FILING CLAIM

_____
ADDRESS

_____
CITY, STATE ZIP CODE

FOR OFFICE USE ONLY

Claim No.

ATTACHMENT A

NAME: _____
LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER: _____ - _____ - _____

DATE OF BIRTH: _____ _____ _____
MONTH DAY YEAR

GENDER: _____ _____
MALE FEMALE

Are you entitled to Medicare Benefits? _____ _____
YES NO

Are you receiving Benefits? _____ _____
YES NO

Have you ever recieved Medicare Benefits? If so, when? _____
DATE

I _____ certify the foregoing information to be true and correct.

Dated at _____ this _____ day of _____, 20 _____ .

_____
SIGNATURE